REPORTING PRESSURE ULCERS VIA BDDS INCIDENT REPORT

A significant illness or injury is considered reportable under the BDDS Incident Reporting Policy. Pressure ulcers fall under the category of "significant illness or injury" and are therefore reportable. An incident report needs to be completed for a pressure ulcer that meets the nationally accepted standards for stage 2, 3, or 4 as defined below. As a follow-up to the initial incident report, a monthly incident report shall be submitted regarding the pressure ulcer until it is healed.

- Stage I: Nonblanchable erythema of intact skin, the heralding lesion of skin ulceration. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may also be indicators.
  Stage II: Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.
  Stage III: Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.
  Stage IV: Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule).

Incident report and follow-up monthly reports will include

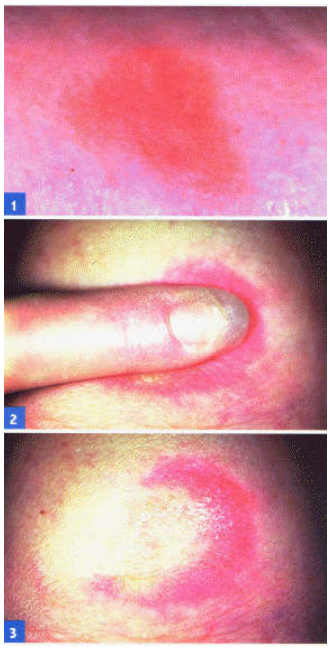
- Specific anatomical location of the PU
- Measurement (in cm) the length, width and depth
- Description of any sinus tracts, tunneling, undermining, necrotic tissue, discharge or exudate's quality and quantity

<u>Not a Stage 1 Pressure Ulcer, at this point is a "red area".</u>
Erythema, intact and blanchable

- Erythema = reddened skin
- Intact = no abrasions, tears, or blisters
- Blanchable = a reddened area is gently pressed in the middle of the red area for approximately 1 second. Remove the finger and see if the area where you pressed is white. If so, then it is blanching. If the area

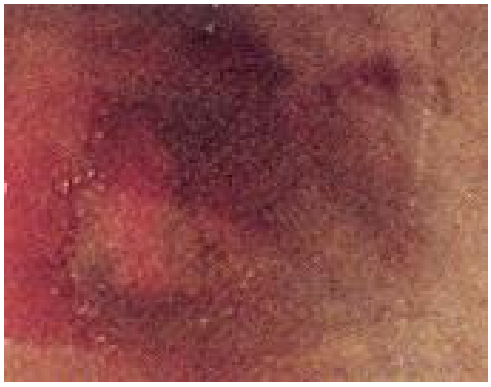
where you pressed remains red, then it is nonblanching. The photos to the right show a blanching reddened area.

- Without appropriate treatment at this time, the red area will most likely progress to a PU. It will not necessarily go to a Stage 1.



Stage 1 PU

Nonblanchable erythema of intact skin, the heralding lesion of skin ulceration. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may also be indicators.



- Nonblanching = when gently pressed on with a finger, the red area does not temporarily turn to a white or lighter color (seen in person with darker skin tone)

- Heralding lesion = what the skin looks like before it opens into an open wound

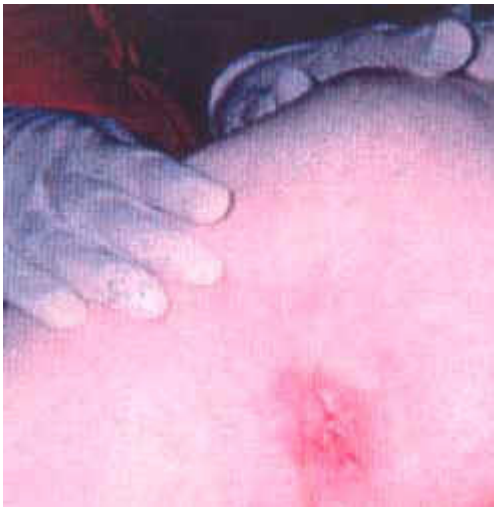
- Edema = swelling, looking puffy

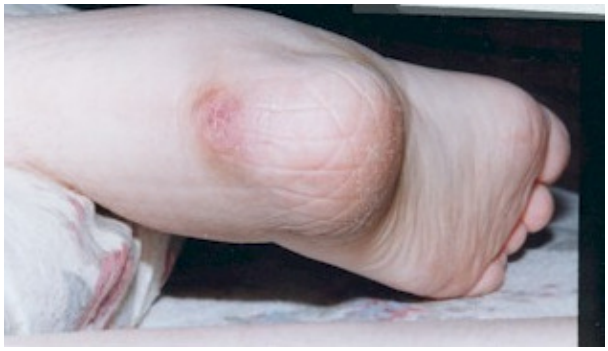
Induration = hardening of tissue which usually feels soft

Stage 2 PU

Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

- Thickness of epidermis AND dermis together is approximately 0.9mm. This is about the same thickness as 2 sheets of paper.
- Epidermis = outermost layer of cells on skin
- Dermis = next to outermost layer of skin



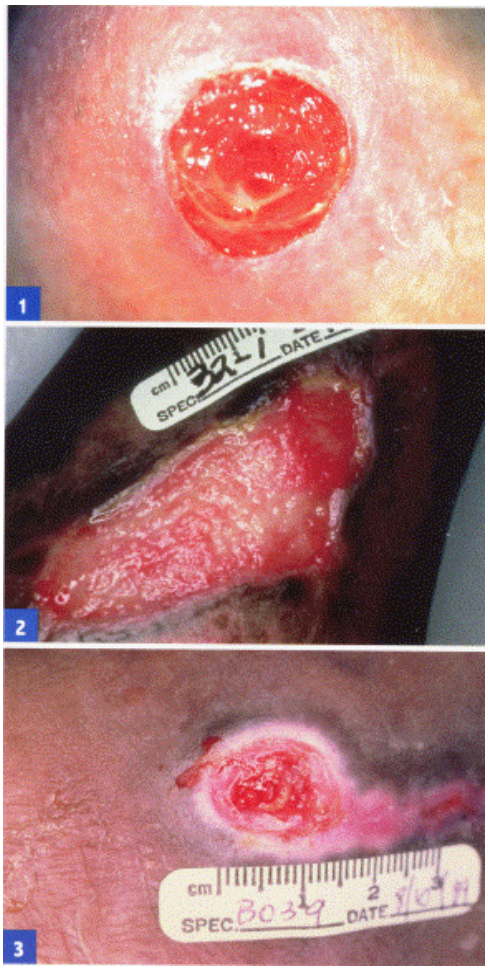


<u>Stage 3 PU</u>

Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend

down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

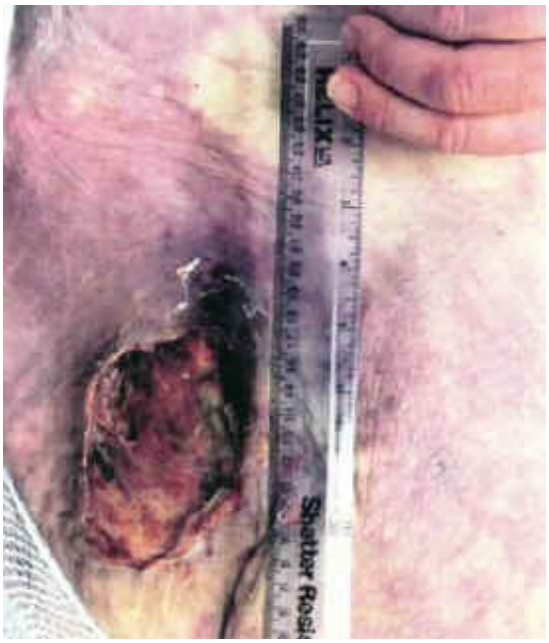
- Full thickness skin = epidermis and dermis both
- Subcutaneous = directly underneath the skin
- Necrosis = dead skin or tissue, usually looks black
- Fascia = membrane separating muscles or attaching skin tissue to underlying layers
- Undermining = edges of wound are larger that the opening of the skin.
- Tracts or tunneling = irregular, deep extensions of the wound further into the tissue. For example, a wound opening may appear to be very small but have tunneling or tracts down to the underlying bone.

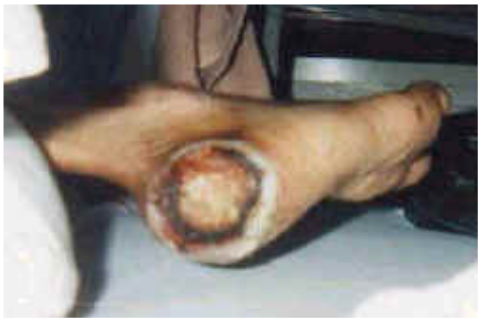


Stage 4 PU

Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule).

- Wound goes into muscle and can progress through to underlying bone
- Necrotic tissue (in picture to the right) is black, dead tissue and is also called "eschar"
- A wound that is covered by necrotic tissue, "eschar", cannot be staged accurately until the covering of dead tissue is removed
- Debridement = removal of dead tissue





Reverse staging

Clinical studies indicate that as deep ulcers heal, the lost muscle, fat and dermis are NOT replaced. The wound fills in with "granulation tissue" instead. Given this information, it is not appropriate to reverse stage a healing ulcer. For example, a pressure ulcer stage 3 does not become a stage 2 or a stage 1 in your documentation during healing. You must chart the progress by noting an improvement in the characteristics (size, depth, amount of necrotic tissue, amount of exudate, etc.). [Taken from the NPUAP Report Vol.4, No.2, September 1995]